SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case ref: 201305516, Grampian NHS Board
Sector: Health
Subject: Clinical treatment; diagnosis; complaints handling

Summary
Mrs C was suffering from abdominal pain, and was seen at a gynaecology out-patient clinic following referral by her GP Practice in November 2012. She was diagnosed with uterine fibroids in January 2013. Mrs C was admitted to a ward at her local hospital (in another NHS board area) due to the pain. In February 2013, Mrs C's GP contacted the consultant gynaecologist (Consultant 1) in charge of the out-patient clinic, requesting that she be placed on the list for surgery due to the impact her condition was having on her life. Consultant 1 replied to say further discussion was required within the multi-disciplinary team; Mrs C was offered another appointment at the clinic on 2 April 2013. Mrs C decided to seek private treatment, and had successful private surgery on 4 April 2013.

Mrs C made a complaint in June 2013 about the care and treatment she received, as well as communicative difficulties she had had when trying to contact Consultant 1. She received a reply in August 2013, apologising for the administrative backlog that caused delay with her care and treatment. The Board also said it was unlikely Mrs C would have been seen earlier than 2 April 2013 due to the gynaecology service's waiting times overall. Mrs C complained again and the Board issued a final response in February 2014. At this time, Mrs C was told that, in February 2013, Consultant 1 had made a decision that she should be referred for surgery. An appointment for 4 April 2013 was to be offered; a telephone call was made by the Board to her GP Practice on 4 March 2013. Consultant 1 told us that this had been left with the GP to discuss with Mrs C.

My investigation found that more prompt action should have been taken by the Board given Mrs C's worsening condition, and that there was a lack of urgency which meant Mrs C's care plan was not re-assessed. I concluded that to expect Mrs C to wait for a further clinic appointment in April 2013 was not reasonable. In addition, it was not reasonable that Consultant 1 had only contacted the GP Practice by telephone to advise of the offer of surgery; contact should have been made in writing to ensure Mrs C was aware of her options. It was not

reasonable to expect the GP Practice to pass on a message about the offer of surgery. In my view, it was likely Mrs C would not have sought private treatment had she known the same procedure would have been available via the NHS at the same time. I also found that the Board's responses to Mrs C's complaints were delayed, having been received well outwith the timeframes within the Board's complaints handling procedure.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) reimburse Mrs C for the cost of her private surgery on production of receipts;	15 July 2015
(ii) apologise to Mrs C for the failures in communication identified in this investigation;	17 June 2015
(iii) confirm that steps have been taken to address the administrative communication failings identified during their investigation of Mrs C's complaints;	17 June 2015
(iv) review the gynaecology department's internal and external communication arrangements to determine what improvements can be made;	15 July 2015
(v) review the management procedure for the care and treatment of patients like Mrs C who live in another NHS board area;	15 July 2015
(vi) apologise to Mrs C for the delays in responding to her complaints;	17 June 2015
(vii) confirm that a process has been put in place to ensure that a complainant's further comments are addressed timeously; and	17 June 2015
(viii) review arrangements with Mrs C's local NHS board for management of similar joint complaints.	1 July 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial

and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C raised her complaint following treatment she received from Grampian NHS Board (the Board). Mrs C was referred to the Board by her GP practice as a result of abdominal pain she was suffering from. Following investigation she was diagnosed with uterine fibroids (benign growths that can occur in the womb).

2. The complaints from Mrs C I have investigated are that the Board's:

(a) care and treatment in early 2013 were unreasonable, (*upheld*); and

(b) complaints handling was unreasonable (*upheld*).

Investigation

3. The investigation of this complaint involved reviewing the information received from Mrs C and the Board. My complaints reviewer also made a number of further enquiries with the Board and Mrs C's GP practice. Independent advice was obtained from a consultant gynaecologist (Adviser 1); a consultant physician (Adviser 2) and a general practitioner (Adviser 3) during the course of the investigation.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mrs C attended at Consultant 1's gynaecology out-patient clinic on 19 November 2012 following a referral from her GP practice. A magnetic resonance imaging (MRI) scan (a scan used to diagnose health conditions that affect organs, tissue and bone) arranged following this appointment was carried out on 3 January 2013 and Mrs C was diagnosed with uterine fibroids. Mrs C called NHS 24 on 20 January 2013 as she was in severe abdominal pain. She was advised to attend at accident and emergency where she was admitted to a ward at her local hospital (in another NHS board area) for nine days.

6. Mrs C's case was discussed at the Board's multi-disciplinary team (MDT) meeting on 6 February 2013. The notes of the MDT meeting confirm that they were aware Mrs C had been admitted to her local hospital and had developed bruising in her groin area. Intra-abdominal bleeding (bleeding within the abdominal cavity) was considered as a possible cause for this. The MDT also

noted that Consultant 1 advised Mrs C's condition should be managed conservatively with a further assessment.

7. On 8 February 2013 Mrs C's own GP (GP 1) wrote to Consultant 1 requesting that she be placed on the list for surgery directly due to the impact that the condition was having on her life. GP 1 explained that Mrs C had been admitted to her local hospital and was now taking MST 10 milligrams (morphine) twice a day. It was noted that she had been unable to reduce the dose of morphine due to the severity of her pain and was also taking regular paracetamol and ibuprofen. Consultant 1 was also made aware that Mrs C was unable to work and could not be left alone at any time as the morphine made her woozy.

8. This correspondence had to be chased up on 18 February 2013 as no response had been received. Consultant 1 replied on 26 February 2013 advising that he was not convinced that fibroids could be totally responsible for such severe pain. He considered that a review by the pain team was an option and asked that this be discussed further with Mrs C. Consultant 1 also advised that Mrs C's name would be put down for discussion in the MDT to review the MRI results. An appointment was allocated to Mrs C at Consultant 1's out-patient clinic on 2 April 2013.

9. Mrs C told us that she could not continue with the pain she was experiencing. In attempt to find relief from her symptoms, she decided to seek private medical assistance despite the fact that she did not have insurance. On 14 February 2013 her GP practice made a referral to a private hospital and Mrs C had successful private surgery on 4 April 2013.

10. Mrs C was unhappy with the care and treatment that she received from the Board and made a formal complaint which was received on 6 June 2013.

11. In her complaint, Mrs C explained that in addition to her concerns about the care and treatment she received, there had also been issues with communication. Mrs C advised that after her MRI scan, she contacted Consultant 1's secretary to find out if there was a date for surgery as she had been advised at the November 2012 clinic appointment that a hysterectomy (surgery to remove the uterus) was likely to be required. Mrs C complained that she was advised there was a five week typing backlog so it would be some time before they contacted her.

12. Mrs C advised that after discharge from her local hospital, she had called Consultant 1's secretary on a number of occasions and left messages for a call back but none was received. She was finally able to speak with the secretary after calling again on the afternoon on 5 February 2013. Mrs C said she was advised that her case was to be reviewed the following day. Mrs C advised that she received a call from the secretary on 8 February 2013 and was offered the out-patient clinic appointment on 2 April 2013. Mrs C said that she was very upset by this and did not feel she was being cared for. Mrs C complained that she felt she had been left with no option but to seek private medical care due to the considerable effect of her condition on her quality of life.

13. Mrs C received a response to her complaints dated 23 August 2013. The Board apologised to Mrs C for the delay that their administrative backlog caused with regard to her care. They advised that this situation was brought about by annual leave and sickness absence within the team resulting a reduced capacity. The Board advised that they had addressed this by increasing the input to the department to ensure that such delays do not directly affect patient care again.

14. The Board also apologised that Mrs C had to make repeated calls to the secretarial team before she received a response. They advised that the team leader had raised this issue with staff and reinforced the requirement to take notes of telephone calls from the public as well as their responsibility to act on these timeously.

15. The Board noted that Mrs C was unhappy with the 2 April 2013 appointment offered to her but advised that due to waiting times in the overall gynaecology service, it would have been unlikely that she would have received an earlier appointment, even if she had travelled to a different hospital rather than attending at the next local clinic.

16. The Board advised that they had taken Mrs C's feedback on board to improve their service and that they would be putting actions into effect as a result. In relation to the concerns subject of this investigation, the Board advised that they would improve communication to try to reduce patient anxiety and identify who should be responsible for communicating with the NHS if a patient is transferring to private care.

17. Mrs C was unhappy with the Board's response and on 29 September 2013 she wrote to them with a number of further concerns. The Board issued their final response to Mrs C's compliant on 10 February 2014. In this correspondence Mrs C was advised that Consultant 1 was only made aware of her admission to the local hospital with worsening pain when he returned to work on 22 February 2013 following a period of annual leave. They informed Mrs C that he then discussed her case with the Divisional Clinical Director (Consultant 2), who suggested that she was offered a date for surgery of 4 April 2013. The Board advised that Consultant 1 was then informed that Mrs C had been referred for private treatment.

18. In conclusion, the Board advised that Consultant 1 did not receive the results of the MDT meeting until his return from annual leave. From a clinical governance perspective, they informed Mrs C that Consultant 1 and the gynaecology team feel that it is important not to proceed with surgery until all investigations are completed. The Board advised that in the meantime, patients should be started on analgesia and investigations expedited wherever possible. As Mrs C's mass was a fibroid, Consultant 1 considered it was very important to discuss the options at a clinic appointment. Consultant 1 apologised for the fact that Mrs C had to wait for three months to see a consultant gynaecologist.

(a) The Board's care and treatment in early 2013 were unreasonable

19. Mrs C was diagnosed with uterine fibroids following her MRI scan on 3 January 2013. She was admitted to her local hospital with abdominal pain on 20 January 2013. Information about Mrs C's admission to her local hospital was shared with the Board and noted at the MDT meeting of 6 February 2013. The MDT notes indicate that Consultant 1 recommended conservative management of Mrs C's condition with further assessment. On 26 February 2013 Consultant 1 advised Mrs C's GP that he was not convinced that her fibroids could be totally responsible for her pain and continued to recommend conservative management including a possible referral to the pain team. Consultant 1 also advised that Mrs C's name would be put down for review in the MDT. A further appointment was arranged for Mrs C at Consultant 1's clinic on 2 April 2013.

20. During this period Mrs C made a number of calls to Consultant 1's secretarial team, leaving messages that were not returned. The letter sent to the Board by GP 1 dated 8 February 2013 also had to be followed up as no reply was received.

21. Consultant 2 recommended that Mrs C was offered a slot in Consultant 1's theatre list for 4 April 2013. A handwritten 'post it' note within the papers provided by the Board indicates that this discussion took place on 1 March 2013 and that a call was made to Mrs C's GP practice on 4 March 2013 to advise of this offer of surgery. This note also indicates Consultant 1 was advised during this call that Mrs C had been privately referred on 15 February 2013.

22. In response to a further enquiry made during this investigation, the Board informed my complaints reviewer that Consultant 1 left the surgery offer to be discussed further with Mrs C's own GP and/or Mrs C herself. They went on to say that Consultant 1 would have expected Mrs C's GP practice to contact her to discuss the surgery and then let him know whether she wished to have the procedure through the NHS.

23. During my investigation, Mrs C's GP practice confirmed that Consultant 1 contacted them on 4 March 2013 and provided a copy of the relevant entry from Mrs C's medical records. This stated that Consultant 1 had telephoned them to see if Mrs C was still in pain and advised that whilst he believed that her fibroid was unlikely to be the source of the pain, he was happy to offer laparoscopy (keyhole surgery) in April if this was still desired. The GP who spoke with him (GP 2) advised that a private referral had been made and it was noted that if Consultant 1 was required, he should be emailed as he would be out of the country until April. There is no evidence within the entry that GP 2 agreed to pass on any message regarding an offer of surgery. The Board have not provided any evidence that such an arrangement was made with Mrs C's GP practice. There is no further reference to Consultant 1's offer of NHS surgery in Mrs C's GP patient record between 4 March 2013 and 4 April 2013. A telephone consultation took place with GP 1 on 11 March 2013 but there is no evidence that Consultant 1's call was discussed. The practice informed my complaints reviewer that GP 2 is no longer employed by the practice and that they were unable provide a statement from this doctor. Mrs C was seen by GP 1 on 20th June 2013 when she advised that her abdominal pain had resolved after her surgery.

24. Mrs C did not attend her appointment at Consultant 1's out-patient clinic on 2 April 2013 and had her successful private treatment on 4 April 2013. As previously indicated, Mrs C has advised that she was unaware NHS surgery

was available on 4 April 2013 until she received the final response to her complaint.

Medical advice

25. My complaints reviewer asked Adviser 1 whether Consultant 1 had taken reasonable action after receiving the results of the MRI scan. Adviser 1 noted that Mrs C's GP practice had sent Consultant 1 a letter in mid-December 2012 explaining that her pain was worsening and that there was a concern about possible ovarian cancer. Adviser 1 commented that no response was provided until mid-January 2013 when Consultant 1 had seen the result of the MRI scan. Whilst Consultant 1's response provided reassurance that cancer was very unlikely, Adviser 1 did not consider that that he acknowledged Mrs C's symptoms were worsening considerably. In Adviser 1's view, there should have been a more positive answer to the issue of the symptoms with arrangements for review in clinic as soon as possible.

26. Adviser 1 noted that that the MRI suggested a benign condition, ie uterine fibroids. He went on to explain that the MDT is a group who advise on the likelihood of the presence of cancer and its treatment. They do not, therefore, generally advise on the treatment of benign conditions which would tend to revert to the discretion of the consultant caring for the patient, depending on their symptoms. Adviser 1 said that follow up in Consultant 1's out-patient clinic was the correct plan for Mrs C's care but considered that waiting until April for an appointment was too long given the clinical circumstances.

27. Adviser 1 also considered that it would have been reasonable for Consultant 1 to write directly to Mrs C and copy this to her GP practice rather than solely communicating with the practice. He noted that Consultant 1 did not appear to have contacted Mrs C directly at any point. In Adviser 1's view, this would have simplified and expedited communication with the patient by removing the need for her to find out at second hand what the care and treatment plan was for her. Adviser 1 considered this to be particularly the case if Mrs C was contacting Consultant 1's secretary directly. He also considered that Consultant 1 could have spoken to Mrs C on the telephone. Whilst noting that many consultants speak to patients this way, he acknowledged that it is generally not standard practice but considered that in the particular circumstances of this case (there is a considerable distance between Mrs C's home and the Board) it could have offered a means to reduce the need for follow up out-patient appointments. Adviser 2 also commented that speaking

directly to Mrs C on the telephone would have been reasonable in this case given the distances involved.

28. Adviser 1 considered that there appeared to have been a degree of dismissiveness about Mrs C's worsening pain which was illustrated by slow responses to correspondence from her GP practice and the content of some of Consultant 1's letters including that of 26 February 2013. Adviser 1 said that whatever Consultant 1's personal view was on the likelihood that Mrs C's fibroids were the cause of her pain, she was clearly in pain and this should have merited an urgent clinical review.

29. Adviser 1 considered that Consultant 1 should have written to Mrs C and/or her GP practice after Consultant 2 advised him to offer his patient a slot in his theatre schedule for 4 April 2013. He advised that it was not reasonable to make a telephone call to Mrs C's GP practice and expect a message to be passed on.

30. Adviser 1 commented that the possibility of hysterectomy should have been discussed directly between Consultant 1 and Mrs C before a final decision was made for surgery. He highlighted that this would be an important part of the informed consent process. Adviser 1 considered that this should have happened in an urgent out-patient appointment; however, given the practical issue with distance, it may have been an acceptable compromise for him to speak with Mrs C on the telephone to discuss the proposed operation. Adviser 1 reiterated that simply telephoning the GP practice was not sufficient communication on this very important clinical issue.

31. Adviser 1 said that discussion between Mrs C and Consultant 1 in advance of the proposed surgery date was essential so that the pros and cons could be addressed. He considered that if there had been good communication about this possibility with Mrs C, then it is likely that she would not have sought referral to the private sector. Adviser 1 went on to say that even if private surgery had already been arranged, Mrs C could have cancelled this if she had been aware that she could have had NHS surgery free of charge at around the same time.

32. Adviser 1 concluded that there were delays in organising appropriate follow up of Mrs C's condition and evidence of very poor communication. He advised that these issues meant that Mrs C organised private care at

considerable expense when it appears that she could have been treated by the NHS within a similar timeframe.

33. My complaints reviewer asked Adviser 3 to comment on the involvement of Mrs C's GP practice. Specifically, Adviser 3 was asked whether it was reasonable for Consultant 1 to make Mrs C's GP practice responsible for passing on an offer of surgery. Adviser 3 said that it was not reasonable for Consultant 1 to do this. She advised that it is not normal procedure for a hospital specialist to contact a GP to ask them to pass on an offer of surgery to a patient. Adviser 3 explained that the normal procedure would be for the specialist to contact the patient directly by letter. She went on to advise that Mrs C had been referred to the Board and as such the responsibility for management lay with the gynaecology team. She commented that it is not the role of the GP to discuss potential surgical options with a patient and made reference to the General Medical Council (GMC) guidance Good Medical Practice on delegation and referral. An extract of this guidance can be found in Annex 3 of this report.

34. Adviser 3 considered that if GP 2 had agreed to directly pass on this information then they should have done so, however, she noted that there is no entry in the clinical record that confirms that this action was agreed and commented that it would be extremely unusual for a GP to agree to do this. Adviser 3 said that the clinical entry in Mrs C's GP record for 4 March 2013 suggests that Consultant 1 called the GP practice for an update on the patient's clinical care and GP 2 advised him that Mrs C had now accessed private health care services. She considered that the clinical entry for 4 March 2013 did not suggest Consultant 1 specifically asked GP 2 to inform Mrs C that he wanted to offer her a laparoscopy procedure and as such, it would be reasonable to assume that the usual process would be followed ie writing directly to the patient.

35. My complaints reviewer asked Adviser 3 whether it was reasonable that GP 1 had not advised Mrs C of the call from Consultant 1 during a telephone consultation that took place on 11 March 2013. Adviser 3 noted that GP 1 was unable to recall the conversation of 11 March 2013 but had advised that based on her notes at the time, Consultant 1's telephone call to the practice the previous week was not mentioned to Mrs C. Adviser 3 said that she did not consider it a failing on the part of GP 1 that Consultant 1's call was not mentioned and that there were several reasons for this. She advised that it

would have been the responsibility of GP 2 who took the call on 4 March 2013 to advise Mrs C of the details but only if they had agreed to do so. As previously indicated, Adviser 3 did not consider there to be any evidence that this arrangement was made. Adviser 3 explained that it is not routine for GPs to discuss previous consultation entries made by other doctors with patients as GPs will assume that these have been managed appropriately by the person who made the entry. She reiterated that the clinical entry made on 4 March 2013 does not suggest that GP 2 had been instructed to pass on a message to Mrs C about potential surgery. Finally, Adviser 3 commented that GPs will frequently leave messages in patient records if there is information that needs to be shared at the next consultation/contact but that it is usual for this to be clearly marked with an instruction such as 'discuss at next consultation'. There is no instruction on the 4 March 2013 entry.

36. Adviser 3 concluded there was no evidence of unreasonable care on the part of the GP practice and that as Mrs C had been referred to the Board, responsibility for management lay with the gynaecology team, not the GP practice.

37. Adviser 2 was also asked to comment on the way that Consultant 1 communicated the offer of surgery. He advised that the decision to offer surgery represented a change to Mrs C's NHS care that she would have been likely to accept. Adviser 2 said that, particularly for a complex issue such as this, the Board should have communicated with Mrs C directly and in writing, not just via her GP practice. Adviser 2 did not consider it reasonable to communicate the change of plan for her NHS care by telephone through her GP practice who were a third party in her care. He advised that Consultant 1 had not communicated with Mrs C in a reasonable way and referred to the GMC's Good Medical Practice guidance which states:

> '49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:
>
> 1. a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties
>
> …
>
> 2. b. the progress of their care, and your role and responsibilities in the team.
>
> …'

Adviser 2 found that in line with this guidance, Consultant 1 should have communicated directly with Mrs C and not delegated to her GP practice. Adviser 2 said that the GMC guidance for delegating care is also clear and states:

> 'When you do not provide your patients' care yourself … or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.'

He considered that this also meant responsibility for informing Mrs C of the surgery offer should not have been delegated this to the GP practice. Adviser 2 commented that Consultant 1 should have communicated directly with Mrs C and that this could have been done by telephone call, letter, or review at the clinic. He considered that no good reason for not using these methods of communication had been provided to justify the action taken.

38. Overall, Adviser 2 found that Consultant 1 did not work in partnership with Mrs C and that his actions were so poor, he could not be certain Mrs C would receive the message or sufficient information to make an informed decision about an operation.

(a) Decision

39. The Board have accepted that there have been failings in terms of their communication in this case, particularly delays as a result of the administrative backlog and difficulties with telephone calls to Consultant 1's secretary. I acknowledge that the Board have apologised in this regard and taken steps to address these matters.

40. There are, however, further issues which are concerning. In the Board's final response to Mrs C's complaint, they advised that Consultant 1 had been unaware of Mrs C's admission to her local hospital until his return from leave on 22 February 2013. During the investigation of this complaint, the Board informed my complaints reviewer that Consultant 1 was on leave from 11 February 2013 until 22 February 2013. At the MDT meeting on 6 February 2013, Mrs C's admission to her local hospital was discussed. Consultant 1 was not on leave at this point and it is unclear how the MDT could have been aware of the worsening in Mrs C's condition when the consultant in charge of her care was not. Furthermore, I note that even after Consultant 1 became aware of the deterioration in Mrs C's condition, this did not prompt any

change in the plan for her treatment as evidenced by his letter to Mrs C's GP of 26 February 2013. The advice I have received is clear that whilst follow up in an out-patient clinic was appropriate for Mrs C, there was a lack of appropriate urgency in arranging this particularly as her GP practice had made it clear that her symptoms were beginning to worsen in December 2012 prior to her MRI scan. Waiting until 2 April 2013 was not reasonable for a patient in her circumstances.

41. After Consultant 1 had discussed Mrs C's case with Consultant 2, further communication issues arose. The advice I have received is clear that it was not reasonable to telephone Mrs C's GP practice and expect a message to be passed on about an important clinical matter such as a new offer of surgery. All three advisers consulted in this case agreed that this change to the plan for Mrs C's care should have been communicated in writing. I am concerned that this was not identified as a failing by the Board during their investigation of Mrs C's complaint. If this action had been taken instead of leaving a message with the GP practice, any doubt as to whether Mrs C was aware of the potential for NHS treatment would have been eliminated. There is no evidence that GP 2 agreed to pass on any message about Consultant 1's offer of surgery and there has clearly been some confusion over what was arranged during this call. If a letter had been issued as a follow up, the impact of this confusion would have been minimised. Given that the offer of surgery was a marked change from the Board's previous plan for treatment, more care should have been taken to ensure that Mrs C was fully informed of her options.

42. I am satisfied that the failing in relation to the communication of the NHS surgery offer lies with the Board, not Mrs C's GP practice. The advice I have received is that responsibility for the management of Mrs C's gynaecology care and treatment lay with the Board as she had been referred by her GP. I note the GMC guidance that clinicians are not accountable for the actions or omissions of those to whom they make referrals.

43. I have also received advice that the possibility of hysterectomy should have been discussed directly between Consultant 1 and Mrs C before a final decision was made for surgery. The advice highlighted that this forms an important part of the informed consent process. Whilst I acknowledge that telephoning patients directly is not routine, the Board should consider whether this form of communication could have a role to play in the management of patients like Mrs C who live at distance or in remote areas. I am aware that an

out-patient clinic appointment had been arranged for Mrs C on 2 April 2013, two days before the proposed surgery. Given that she was receiving private care and was unaware that the Board had changed the plan for her treatment, I do not consider her lack of attendance unreasonable.

44. There is evidence of a lack of appropriate urgency in this case and the standard of the Board's communication has had a significant impact on Mrs C's ability to make informed decisions about her care and treatment. The advice received is that poor communication led to Mrs C incurring considerable expense on private treatment when it appears she could have been treated by the NHS within a similar timeframe. The Board have not acknowledged that their actions had any impact on Mrs C's decision making process.

45. In view of these findings, I uphold this complaint.

(a) Recommendations

46. I recommend that the Board:	*Completion date*
(i) reimburse Mrs C for the cost of her private surgery on production of receipts;	15 July 2015
(ii) apologise to Mrs C for the failures in communication identified in this investigation;	17 June 2015
(iii) confirm that steps have been taken to address the administrative communication failings identified during their investigation of Mrs C's complaints;	17 June 2015
(iv) review the gynaecology department's internal and external communication arrangements to determine what improvements can be made; and	15 July 2015
(v) review the management procedure for the care and treatment of patients like Mrs C who live in another NHS board area.	15 July 2015

(b) The Board's complaints handling was unreasonable

47. Mrs C raised her complaint through her local NHS board on 3 June 2013. Her original complaint included concerns about the care and treatment she had received from the Board and at her local hospital. Her local NHS board took ownership and an arrangement was made that the Board would forward the findings of their investigation to her local NHS board to provide a collated response.

48. Mrs C's local NHS board answered her complaints about their service on 30 July 2013 and advised that they had not yet received a report from the Board on their investigation.

49. The Board's response to Mrs C's concerns was issued on 23 August 2013. She remained dissatisfied with their position on her complaints and wrote directly to the Chief Executive on 29 September 2013. This correspondence was received by the Board on 1 October 2013.

50. The Board acknowledged receipt of this letter on 18 October 2013 and suggested a video conference meeting to discuss Mrs C's concerns. Mrs C contacted the Board on 1 November 2013 to advise that she did not want a meeting and preferred to receive a written response.

51. An entry was added to Datix (the electronic complaint record) for this case on 3 February 2014 stating that there had been a delay as the complaint did not appear in the open section on the electronic system and was, therefore, missed. It was asked that Datix was reopened in circumstances such as these in future to provide a failsafe and stop such an error occurring again.

52. The Board provided their final response to Mrs C's complaints on 10 February 2014.

(b) Decision

53. The Board's complaints handling procedure states that formal complaints will be acknowledged within three days and a response issued within 20 working days of the complaint being received. In the papers that Mrs C provided for my investigation, there was an undated letter from the Board's feedback service apologising that they had been unable to respond to her complaints within the 20 working days timeframe. This correspondence noted that Mrs C's complaint had been received on 6 June 2013. It was some 11 weeks after this date that Mrs C received the Board's initial response to her complaints. This is clearly well outwith the expected timeframe.

54. There was a further substantial delay in responding to Mrs C's additional concerns which were outstanding in excess of 18 weeks. As previously indicated, the reason for this unacceptable delay has been identified by the Board and steps proposed to prevent a recurrence of a similar error in the future.

55. In light of the failures identified in the handling, I uphold this complaint.

(b) Recommendations

56. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the delays in responding to her complaints;	17 June 2015
(ii) confirm that a process has been put in place to ensure that complainant's further comments are addressed timeously; and	17 June 2015
(iii) review arrangements with Mrs C's local NHS board for management of similar joint complaints.	1 July 2015

57. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
the Board	Grampian NHS Board
Adviser 1	a consultant gynaecologist
Adviser 2	a consultant physician
Adviser 3	a general practitioner
Consultant 1	a consultant gynaecologist
MRI	magnetic resonance imaging
MDT	multi-disciplinary team
GP 1	general practitioner
GMC	General Medical Council
Consultant 2	a consultant gynaecologist and Divisional Clinical Director
GP 2	general practitioner
the local NHS Board	Mrs C's local NHS Board (not Grampian NHS Board)

Annex 2

Glossary of terms

Datix	electronic complaint record
gynaecology	medicine of the female genital tract and its disorders
hysterectomy	surgery to remove the uterus
intra-abdominal bleeding	bleeding within the abdominal cavity
laparoscopy	keyhole surgery
magnetic resonance imaging (MRI) scan	a scan used to diagnose health conditions that affect organs, tissue and bone
uterine fibroids	benign (non-cancerous) growths that can occur in the womb
womb	uterus

Annex 3

List of legislation and policies considered
GMC guidance for doctors Good Medical Practice – Online

Delegation and referral (2013)
1. In Good medical practice we say:
“15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

c. refer a patient to another practitioner when this serves the patient's needs.

…

44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:
a. share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, when you delegate care or refer patients to other health or social care.

45. When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.”

2. In this guidance, we explain how doctors can put these principles into practice when delegating care and making referrals. You are not accountable to the GMC for the actions (or omissions) of those to whom you delegate care or make referrals. You will be accountable for your decisions to transfer care and the steps you have taken to make sure that patient safety is not compromised. Serious or persistent failure to follow this guidance will put your registration at risk.

Delegation
3. Delegation involves asking a colleague to provide care or treatment on your behalf.

4. When delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised.

5. When you delegate care you are still responsible for the overall management of the patient.

Referral

6. Referral is when you arrange for another practitioner to provide a service that falls outside your professional competence.

7. Usually you will refer to another doctor or healthcare professional registered with a statutory regulatory body.

8. Where this is not the case, you must be satisfied that systems are in place to assure the safety and quality of care provided – for example, the services have been commissioned through an NHS commissioning process.

9. The following applies whether you are delegating or referring.

a. You should explain to the patient that you plan to transfer part or all of their care, and explain why.

b. You must pass on to the healthcare professional involved:
- relevant information about the patient's condition and history
- the purpose of transferring care and/or the investigation, care or treatment the patient needs.

c. You must make sure the patient is informed about who is responsible for their overall care and if the transfer is temporary or permanent. You should make sure the patient knows whom to contact if they have questions or concerns about their care.

d. You should check that the patient understands what information you will pass on and why. If the patient objects to a disclosure of information about them that you consider essential to the safe provision of care, you should explain that you cannot refer them or arrange for their treatment without also disclosing that information.

GMC guidance for doctors Good Medical Practice

Establish and maintain partnerships with patients

46. You must be polite and considerate.

47. You must treat patients as individuals and respect their dignity and privacy.

48. You must treat patients fairly and with respect whatever their life choices and beliefs.

49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties

b. the progress of their care, and your role and responsibilities in the team

c. who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care

d. any other information patients need if they are asked to agree to be involved in teaching or research.

50. You must treat information about patients as confidential. This includes after a patient has died.

51. You must support patients in caring for themselves to empower them to improve and maintain their health. This may, for example, include:

a. advising patients on the effects of their life choices and lifestyle on their health and well-being

b. supporting patients to make lifestyle changes where appropriate.

52. You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.